HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Under New Leadership, CMS Continues Emphasis on Quality

Keep focusing on efficient, cost-effective care

There's a new administration in Washington, DC, and new leaders at the helm of the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS). But at CMS, emphasis on quality remains.

Despite the changes in Washington, the focus of case managers has not changed, says **Cheri Bankston**, RN, MSN, senior director of clinical advisory services for naviHealth, a Cardinal Health company. "We know that CMS is still working toward value-based care and that patient outcomes are going to drive the future. There may be some changes, such as shifting bundled payments from being mandatory to being voluntary, but the emphasis in healthcare will continue moving from volume to value," she says.

> "WE KNOW THAT CMS IS STILL WORKING TOWARD VALUE-BASED CARE AND THAT PATIENT OUTCOMES ARE GOING TO DRIVE THE FUTURE."

CMS indicated that it still has a strong commitment to improving quality and patient satisfaction, primarily through value-based care, adds **John Wagner**, associate director at Berkeley Research Group.

For instance, CMS has introduced programs that emphasize quality for every major component of the continuum of care, Wagner points out. "This indicates that CMS is going to continue driving toward value-based reimbursement," he says.

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Quality-based programs also are very popular among commercial payers and government organizations. In fact, some commercial payers are requiring large provider groups and systems to participate in quality programs in order to obtain multi-year contracts, Wagner says.

"Clearly, the commercial payers believe that there is also a lot of benefit to base contracts with networks on quality programs," Wagner says.

The Inpatient Prospective Payment System (IPPS) final rule left all the basic rules about medical necessity and the utilization review process unchanged, says **Kurt Hopfensperger**, MD, JD, vice president of compliance and education at Optum Executive Health Resources in Philadelphia. The final rule, issued in August, made technical changes, such as how readmission penalties are calculated, and minor changes to the hospital-acquired conditions and value-based purchasing program. Not many of those affect case management, Hopfensperger says.

With the continuing emphasis on Medicare spending-per-beneficiary and other quality-based programs, the case management role will continue to grow in importance, he adds.

However, some of the biggest changes initiated by CMS are independent of the IPPS, says **Edward Hu**, MD, CHCQM-PHYADV, president of the American College of Physician Advisors.

For instance, CMS announced that the Medicare Administrative Contractors (MACs) will be conducting Targeted Probe and Educate audits. "This is a significant change because the MACs no longer are auditing everyone, but analyzing claims and focusing on hospitals with the biggest percentage of errors," Hu says. *(For details on the MACs and other audit programs, see related article on page 154.)*

Another example is CMS's recent announcement that it intends to develop voluntary bundled payment initiatives rather than require hospitals to participate. The news came as the agency announced changes to the Comprehensive Care for Joint Replacement initiative that significantly reduced the number of hospitals required to participate and proposed canceling the Episode Payment Models and the Cardiac Rehabilitation Incentive Payment

EXECUTIVE SUMMARY

Despite all of the changes in Washington, DC, the Centers for Medicare & Medicaid Services (CMS) remains committed to providing high-quality, efficient, and cost-effective care.

- CMS announced quality programs for providers throughout the continuum and left intact all rules about medical necessity and utilization review in the Inpatient Prospective Payment System (IPPS) final rule for 2018.
- Case managers should stay informed about CMS changes and continue to prepare for value-based care, bundled payments, and other quality programs.
- It's more important than ever for case managers to be a part of the multidisciplinary team, work closely with the documentation staff, physicians, and nursing, and communicate with their counterparts across the continuum, especially when patients transition.

model that was scheduled to begin Jan. 1, 2018. *(For details on the bundled payments changes and their effect on case managers, see related article on page 152.)*

"The new administration is looking at new, innovative ways to reduce the total cost of care while maintaining quality, and will continue to make changes," Hu says.

But many hospitals are not prepared for constant and rapid change, says **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, based in Bluffton, SC.

"In this fluid environment, case managers should stay informed about what changes impact their day-to-day activities. Case management leadership and physician advisors should be working closely with the compliance and policy departments to help ensure they are getting the information they need to make sure the hospital complies with new regulations," Lamkin says.

For instance, in the IPPS final rule, CMS announced the addition of the 30-day episode of care for pneumonia to value-based purchasing in fiscal 2022, reports **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, FAHIMA, vice president of inpatient services for Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

It's tempting to think about how long it is until 2022 and plan on dealing with it later, Wallace says. She points out, however, that the baseline period for the measure has already ended and that the performance period starts Aug. 1, 2018.

"All of the initiatives instituted by CMS make it extremely important for hospitals to treat patients as efficiently and effectively as possible," Wallace says.

That's why it's important for case managers to familiarize themselves with payer rules and regulations, she says. Pay particular attention to the measures in the hospital inpatient quality reporting program and focus your process improvement projects on those measures, she says.

The problem is that case managers still have one foot in the fee-for-service world and the other in value-based care, Bankston says. "Both have the same goal, which is doing what is best for the patient," she says.

Today's healthcare environment offers case managers a great opportunity to be real agents of change, Bankston adds. She advises case managers to be proactive and continue to prepare for value-based care. "This is where we shine and where we can really lead the charge toward focusing on outcomes and what is best for the patient," she adds.

If every provider focused solely on quality and outcomes, all facets of patient care would be significantly improved, especially the bottom line, Wagner says. "Case managers should be extremely focused on quality and identifying risks for readmissions and putting interventions in place to prevent them," he adds.

As payers continue to emphasize high-quality, cost-effective care in hospital and post-acute settings, case managers should be shepherding patients through the entire episode of care and should review every case, every day for medical necessity, Hopfensperger says. A major focus of case managers should be length of stay, he adds.

"Any time case managers can do anything to prevent a patient waiting another day for a test, that contributes to the length of stay, and ultimately affects the cost of treatment," Wallace says.

For hospitals to succeed in value-based purchasing, case managers must properly identify patients at risk for readmission early in the stay and take steps to help patients avoid coming back, says **Teresa Marshall**, RN, MS, CCM, senior managing consultant for Berkeley Research Group.

"Case managers can help prevent readmissions if they understand each patient's barriers to following the discharge plan, collaborate with the rest of the team to overcome the barriers, and make sure everyone is on the same page when the patient moves to another level of care," she says.

Case managers must move more of their work to the front end of the patient stay, rather than waiting 24 hours or longer to review a chart, Lamkin says. Every entry point should be covered by a case manager who is knowledgeable about the risk areas, she says.

Case management must be proactive in identifying issues at the time of admission that can result in a loss of reimbursement, she adds. This means working with other departments, such as patient financial services and clinical documentation improvement teams, to ensure that all required documentation and authorizations are in place to prevent a denial downstream, she says.

"A good check-and-balance is to track denials for root cause and create a feedback loop to the front-end case managers so they can lead the clinical team to correct deficiencies that result in denials," Lamkin suggests. For instance, if a physician requests a bed for a patient after surgery, there must be a mechanism for case management to review the case and ensure that the patient meets inpatient criteria, or the criteria for an outpatient with observation services, she says.

"Hospitals can't just depend on physicians to choose the correct bed status," she says.

Some hospitals aren't big enough to have a case manager on site 24/7, Lamkin points out. In these cases, she suggests staggering the hours of the staff, with some coming in early and other staying late.

Hospitals have to do more than just become compliant. They have to be as efficient as they can with community resources, Wallace says. "Case managers should make sure that patients have exactly what they need — not more or less. They should focus on the overall efficiency of services delivered and work to ensure a successful discharge," she says.

Work closely with physicians on documentation to the extent that the case management role in your hospital includes documentation improvement, Wallace says.

Almost all CMS quality measures are risk-adjusted, Wallace points out. This means that all of a patient's significant chronic conditions should be documented in the medical record.

"In the past, hospitals focused only on including documentation to indicate a Complication or Comorbidity or Major Complication or Comorbidity that would change the DRG [diagnosis-related group]. But there are hundreds of diagnoses that affect risk adjustment but do not affect the DRG," Wallace says.

"Patients could have five or more complications or comorbidities, and the DRG would be the same as if they had only one. But five complications or comorbidities would have a big impact when the hospital's data is risk-adjusted," she adds.

For instance, when a diabetic patient has hyperglycemia, it doesn't change the DRG but it does affect risk adjustment, she adds.

"Case managers should continue to focus on what we are good at, which is driving outcomes," Bankston says.

Bankston suggests that case managers change their perspectives and instead of concentrating on a patient's acute care needs, analyze what he or she will need during the entire episode of care.

"The challenge is to look outside the four walls of the hospital and assess the entire 90-day episode of care. Historically, we waved goodbye from the hospital door. Now we have to manage the complex episode after discharge," she says. The biggest challenge in the future may be to determine which providers will be the most effective in a particular episode, Bankston says.

"We need to look at the quality of care provided at each step of the patient's journey and determine which has the biggest impact on proven outcomes," she says.

Effective discharge planning is important and requires a balancing act, Wallace points out. Where the patient goes after discharge contributes to the cost of the episode of care and, if the discharge fails and the patient comes back, it affects the hospital's performance on the readmission reduction program, Wallace adds. ■

No Crystal Ball Needed to Know Where CMS May Focus

Be informed about areas that are receiving attention

To get a good idea of what diagnoses CMS will add to the readmission reduction program or other value-based purchasing programs, look no further than the Hospital Inpatient Quality Reporting Program components.

Keep in mind that CMS won't put anything in value-based purchasing that isn't already a part of the inpatient quality measures, says **Susan Wallace**, MEd, RHIA, CCS, CDIP, CCDS, FAHIMA, vice president of inpatient services for Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

On the other hand, anything that is part of the hospital quality reporting program and posted on Hospital Compare is fair game for inclusion in any of the CMS quality-based programs, Wallace says.

Case managers should be informed about how their hospitals perform on the current measures — all of which in the future may be included in value-based purchasing, the readmission reduction program, and the hospital-acquired conditions reduction program, Wallace says. She recommends that case managers review their hospital's performance on the measures and identify opportunities for improvement.

Wallace points out that the hospital quality department has more specific and detailed information than what is published on Hospital Compare. "Case managers and the quality department should work closely to see where the

hospital is vulnerable and where the opportunities are," she says.

In the future, CMS is likely to continue focusing on areas that have received attention in the past, says **Kurt Hopfensperger**, MD, JD, vice president of compliance and education at Optum Executive Health Resources in Philadelphia.

For instance, even though CMS has canceled the cardiac bundled payment initiative, scrutiny is likely to continue because it's a high-cost, high-volume diagnosis group, he says.

"Hospitals' cardiac procedures are under scrutiny from CMS and its auditors, and even the Department of Justice. It's only going to continue," he adds.[1]

In the Inpatient Prospective Payment System final rule for fiscal 2018, CMS announced its intention to add a 30-day episode of care for pneumonia indicator to the efficiency and cost-reduction domain in value-based purchasing, beginning in fiscal 2022.

Even though CMS has not created a bundled payments arrangement for pneumonia, it is treating the 30-day episode as a bundle in value-based purchasing, Hopfensperger says.

The Two-Midnight Rule is here to stay — at least for a while, Hopfensperger says. "CMS has had multiple opportunities to modify the rule and they didn't change anything, including the exceptions for one-midnight inpatient stays," he adds.

CMS has remained silent on the Two-Midnight Rule for almost two years, says **Edward Hu**, MD, CHCQM-PHYADV, president of the American College of Physician Advisors.

The last change was in January 2016 to allow exceptions to the rule on a case-by-case basis, Hu adds. "CMS has stopped issuing new guidance and making changes in the rule. All the Open Door forums on the Two-Midnight Rule were within the first few months after the rule was announced. CMS is sticking with the guidance that's already been issued and so far, has not made changes," Hu says.

However, Hu predicts that the rule will fall by the wayside as initiatives such as bundled payments and Medicare spending-per-beneficiarygrow.

"The Two-Midnight Rule and its focus on patient status is not where CMS is going. As CMS moves toward a risk-sharing environment, patient status will become irrelevant," Hu points out. "What is becoming important is the total cost of an episode of care." ■

For Better Patient Care, Communicate Early and Often

Work closely with clinicians inside and outside the hospital

In today's healthcare world, communicating with other clinicians in the hospital and in post-acute provider organizations is essential to ensure patients receive the care they need to stay out of the hospital and the ED.

"Patient-centered communication is huge," says **Teresa Marshall**, RN, MS, CCM, senior managing consultant for Berkeley Research Group.

Case managers must communicate constantly with other departments and talk to their counterparts in post-acute provider organizations as well as their peers at other hospitals, adds **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, based in Bluffton, SC.

"The more everyone involved with a patient works together and shares information, the better it is for the patient," she adds.

Case managers, treating physicians, and clinical documentation improvement staff comprise a three-legged stool, and interaction between them is essential, Lamkin says.

"The case management department and the clinical documentation improvement staff should become partners and ensure that documentation is correct in real time," she says. "Work closely with the clinical documentation improvement staff and teach them inpatient criteria. Educate the clinical team about how patients flow into the system."

Case managers also should be in constant communication with nursing and ancillary providers and should attend daily rounds on every patient with the entire multidisciplinary team, she says.

She recommends that case management departments have active physician advisors who can act as

liaisons between case managers and physicians, Lamkin says. "Today's healthcare environment makes it more important than ever to engage medical staff," she says.

Population health initiatives and bundled payments are not going away, and case managers need to help their hospital succeed, Lamkin states.

"Continuity of care is still a big focus. Case managers need to understand how the continuum of care is structured, where the patients are coming from, the potential denials they could have, and how to manage care along the post-acute continuum," she adds.

Hospitals should establish a process to improve transitions and communication with providers at the next level of care, Marshall says.

She suggests working with post-acute providers to develop a method to alert providers along the continuum when a patient is treated by a provider at a different level of care.

"There should be some type of trigger so that when case managers assess patients at admission, they will know that they are part of a population managed outside of the four walls of the hospital," she says.

"Hospital administrators should ensure that case managers have the infrastructure so they can identify at-risk patients in the ambulatory and inpatient setting, and as they transition through the continuum," Marshall adds.

She advises hospital-based case managers to work closely with their counterparts in other settings to ensure patients get what they need without duplication of effort. ■

They're Back! CMS Audits Are Ratcheting Up

It has been a while since hospitals were inundated with requests for records from CMS auditors, but that may be about to change.

"After a quiet period, government audits are beginning to ratchet up," says **Kurt Hopfensperger**, MD, JD, vice president of compliance and education at Optum Executive Health Resources in Philadelphia.

Quality Improvement Organizations (QIOs) are reviewing short stays, and Medicare Administrative Contractors are scheduled to reinstitute "probe and educate" audits. In addition, CMS has issued new contracts with Recovery Auditors (RAs).

That's the bad news. The good news is that most of the audits target hospitals that have significant error rates in their claims. That makes case managers even more essential than in the past.

"The key to reducing a hospital's audits is to ensure that case managers assess every patient at the point of entry, and review the status of observation patients to make sure they are in the right status," says **Teresa Marshall**, RN, MS, CCM, senior managing consultant for Berkeley Research Group.

The audits aren't likely to go away, regardless of what the new CMS leadership does, Hopfensperger says.

If the Affordable Care Act is repealed, many initiatives, including value-based purchasing and bundled payments, will be eliminated and Medicare will return to a fee-for-service program.

"In that case, my guess is that the only way CMS could control costs would be to ramp up the auditing process even more," Hopfensperger says.

Meanwhile, here's a look at who is reviewing what:

• The two Beneficiary and Family-Centered Care Quality Improvement Organizations (QIOs) are resuming audits of medical necessity of short stays, focusing on hospitals that submitted claims with a lot of errors. CMS had suspended the audits in 2016 in order to retrain QIOs and ensure consistency in the audit process.

• QIOs no longer are sampling every hospital twice a year. They are focusing on the top 175 providers

EXECUTIVE SUMMARY

Hospitals have had a reprieve from record requests, denials, and appeals, but that's about to change as CMS ramps up its auditing programs.

• The two Beneficiary and Family-Centered Care Quality Improvement Organizations (QIOs) are restarting their audits of stays of less than two midnights, but are concentrating on hospitals that have had a lot of errors.

• CMS has given Medicare Administrative Contractors (MACs) permission to resume "probe and educate" audits that also will focus on hospitals that are significant outliers.

• Recovery Auditors have new contracts and have submitted lists of issues to cover but, under the new contracts, they are limited in how many requests for additional information they may issue to a hospital and must audit hospitals for a variety of issues.

based on the number of one-day inpatient stays or an increasing number of inpatient stays, as well as hospitals that have an error rate of 20% or more, says **Edward Hu**, MD, CHCQM-PHYADV, president of the American College of Physician Advisors.

• CMS is providing the QIOs, Kepro and Livanta, with monthly samples of claims of eligible stays of less than two midnights. The QIOs identify between 10 and 25 cases for review, depending on the size of the hospital, and can repeat the audit every six months.

"The auditors will review the records for medical necessity and look for technical issues, such as a valid, signed inpatient order and the physician's expectation that the patient will stay two midnights," Hopfensperger says.

• CMS has given the Medicare Administrative Contractors (MACs) permission to conduct Targeted Probe and Educate audits of hospitals identified as significant outliers, Hopfensperger says.

The MACs use data analysis to identify the top hospitals out of compliance for billing and "use of certain services." CMS has not given details on exactly how the hospitals will be identified or what "certain services" will be targeted, he says.

The Targeted Probe and Educate process is expected to start in late 2017 and can continue for three rounds, during which the MACs can request 20-40 charts, depending on the size of the hospital. Hospitals chosen for audits are those that the MACs have identified as having a high error rate, Hopfensperger says.

• CMS signed contracts with the five Recovery Auditors (RAs) in the fall of 2016, and they're beginning the audit process. Recovery Auditors in Regions 1-4 will review Medicare Part A and Part B for improper payments. The RA in Region 5, which encompasses the entire U.S., will review durable medical equipment and home health/hospice claims.

Each of the auditors in Regions 1-4 has a lengthy list of issues that CMS has approved for review, Hopfensperger says. Some issues include inpatient DRG coding, inpatient psychiatry bills, medical necessity for some procedures, and admissions not through the ED.

> "THE KEY TO REDUCING A HOSPITAL'S AUDITS IS TO ENSURE THAT CASE MANAGERS ASSESS EVERY PATIENT AT THE POINT OF ENTRY, AND REVIEW THE STATUS OF OBSERVATION PATIENTS."

"All the RAs have similar lists. What is not yet on the list is traditional inpatient versus outpatient medical necessity, but there's no reason CMS can't add that," Hopfensperger says. He recommends that case managers frequently visit their RA's website to stay current on the approved issues for review.

Recovery Auditors are issuing record requests, but so far they are mainly for DRG validation and other limited inpatient issues, as well as automated reviews that can add up to big dollars quickly, reports **Elizabeth Lamkin**, MHA, chief executive officer and partner in PACE Healthcare Consulting, based in Bluffton, SC. "And the RAs can use extrapolation, based on denials," she says.

CMS has reined in RAs somewhat with changes in the auditor's scope of work. For instance, RAs are required to sample all types of cases, which means they no longer can focus on one issue or cases that have charges, Hu adds.

"Level of care became the bread and butter for the RACs [recovery audit contractors] in 2010, but now they're off limits to the RAs, and the QIOs are conducting the short stay reviews," Hu says.

Under the new contract, additional documentation requests (ADRs) from RAs are restricted to 0.5% of a provider's total number of paid bills for all types of claims in the previous year.

CMS can adjust the number of ADRs hospitals can receive depending on the hospital's denial rates, Lamkin says. As the denial rates decrease, so will the number of files RAs can request. On the other hand, if a hospital has a high rate of denials, RAs may request more records to review, she adds.

Hospital appeals of denials issued by RACs in earlier years continue to back up at the administrative law judge level, Hopfensperger reports. Some hospitals took CMS up on its offer to settle appeals for a partial payment of 66% of the disputed amount, but there still is a significant number of cases pending appeal, he adds.

To help with the backlog, CMS is hiring attorneys as adjudicators to help the judges decide cases that don't need formal hearing, he says.

"The adjudicators don't have all the power of judges, but they can take care of the more routine and administrative issues and free the judges up to deal with the significant backlog of appeals," he says. For example, they can dismiss a request when one party withdraws, or send cases back to the auditors for more details. ■

Improved Patient Handoffs Require Comprehensive Approach

Hospitals are paying more attention to patient handoffs as a crucial element in quality and patient safety, with an evolution toward seeing them as not just a distinct task, but more as a comprehensive strategy.

The importance of good patient handoffs has been recognized for years, but healthcare professionals now are looking beyond the primary handoff scenarios such as shift changes and moving a patient from one hospital department to another, says **Faye Sullivan**, RN, healthcare coach for the Studer Group, a consulting group based in Pensacola, FL.

Good handoffs still are vitally important in those situations, but quality leaders also are looking to improve handoffs in other ways.

"The idea of a handoff and what that means has grown recently so that people are now looking at the 30 days after the acute care event in the hospital," Sullivan says. "They are looking at some of the strategies they may have employed in the past, like the post-visit phone call or interdisciplinary rounds, through a new lens and retool those to drive different outcomes from the same strategies."

Hospitals are including the discharge and aftercare process as a patient handoff, Sullivan says, with many using data analytics to determine which patients are most likely to return to the hospital and why, and then formulating a series of post-visit phone calls to address those risks.

"If you go home from the hospital after an appendectomy, we'll call you at day two or three to make sure you're progressing as expected. But if you go home with congestive heart failure, we'll call you at day two or three, but we'll also call you at day seven," Sullivan says. "That's because we know that around day nine or 10, we often see congestive heart failure patients back [in] the hospital because they've not followed through on home care instructions. If we call you back at day seven to find out if you've filled your prescriptions and whether you're gaining weight, we're much more likely to avert readmissions."

Catch Patients in Time

Those patients also receive a call after three weeks because data indicate that they often return to the hospital at about four weeks. Patients leave the hospital "scared straight" about their conditions and determined to do what is necessary to maintain their health, but that conviction wanes over time and their health begins to fail, Sullivan says.

"If we call them at day 21 and ask them to compare the first week after discharge to how they are managing their healthcare now, we can look for slippage and get people back on the right track so they avoid that day 21 to day 30 readmission," Sullivan says. "The concept is not new, but it's been retooled in light of the data showing what we need to pay attention to."

That approach also plays into another facet of patient handoffs getting more attention: the patient's engagement in his or her own healthcare. Hospitals are working to meet patients where they are in terms of understanding, motivation, and ability to care for themselves.

"If I'm a patient who is highly engaged in managing my own health, I may not need that 21-day phone call because I'm less likely to fall off a cliff," Sullivan says. "But if I am a newly diagnosed patient or a patient who has been admitted many times in the past and you know I'm not engaged in managing my care, that will drive not only the frequency of contact, but the style of contact you have with them."

For instance, with patients who are less engaged in their own care, Sullivan encourages healthcare professionals to provide little bits of information more often. Giving them too much information at once overwhelms them and can further disengage them, she says.

'Handover' Conveys Right Message

Sullivan and her colleagues also urge healthcare providers to change the terminology from patient handoffs to patient handovers. They think the word "handoff" sounds like clinicians are offloading patients and the clinician stops caring, whereas the word "handover" conveys that one caregiver is transitioning care to another caregiver in a meaningful and thoughtful way.

"'Handoff' implies that I'm handing you to someone else and I'm washing my hands of you, I'm done," she says. "A 'handover' implies more of a continuum of care. I'm still invested in you and I'm still a member of your care team. Just because you're not in the bed in front

of me doesn't mean I no longer care for you or have any responsibility for you."

That distinction is more than just symbolic, Sullivan says. Healthcare professionals must be encouraged to think of themselves as still involved in a patient's continuum of care even if the patient is not physically under their care now, she says. The patient may have been transferred to another department or another professional's care, but the professional making the handoff must still be ready to participate by providing needed information or other support, she says.

"The days of looking at the doors to your unit and thinking you're off the hook once they pass through those doors are over," Sullivan says. "It's not about who has custody of the patient now. It's about the organization and everyone involved taking responsibility for the whole continuum of care."

Combine Multiple Strategies

The best strategies for improving patient handoffs take a more comprehensive approach instead of focusing exclusively on that moment when a patient's care is transferred from one caregiver to another, says **Christopher Landrigan**, MD, MPH, pediatric hospitalist at Boston Children's Hospital and associate professor of pediatrics and medicine at Harvard Medical School. Landrigan also is founder and a board member of the I-PASS Patient Safety Institute, which promotes safe patient handoffs, and principal investigator with the I-PASS Study Group.

I-PASS is a mnemonic used to ensure caregivers address the key elements of a good handoff: Illness severity, Patient summary, Action list, Situation awareness and contingency planning, and Synthesis by receiver.

He notes that the I-PASS program originated with efforts to reduce resident work hours, which resulted in more patient handoffs. As Landrigan and colleagues looked at how to make those handoffs safer, they realized that other successful quality improvement efforts took a broad approach.

"When you look at reducing hospital-acquired infections, the most successful interventions were not just focusing on handwashing as the sole thing you should do, but, rather, a whole series of complementary interventions that resulted in reducing infections," Landrigan says. "They optimized handwashing efforts with improved use of sterile precautions, prepping the site well, avoiding the femoral site — a whole series of little steps that, in the aggregate, drove hospital-acquired infections down by about 80%."

Landrigan and his colleagues took the same approach with patient handoffs, not focusing on just a computerized handoff tool or teamwork training, but also on bundling those strategies with others for a comprehensive way to improve handoffs. They developed a training program, an improved verbal process with the I-PASS mnemonic, and a handoff tool that reinforces best practices.

Is It a Priority?

A hospital quality professional seeking to improve patient handoffs must first determine whether it is a priority for the organization. Although good handoffs should be the goal of all healthcare professionals, an organization may not be able to prioritize it now, and that will stymie any improvement effort, Landrigan says.

"This requires a substantial amount of support and input from the highest levels. This is a culture change," Landrigan says. "You're asking people to speak differently, and that requires a lot of time and effort to make it happen day in and day out for every patient every time. It's one thing to train people, but it's another thing entirely to get people to actually change what they do daily."

A common occurrence is to provide training, maybe even change the electronic medical record to encourage proper handoffs, but two months later no one is doing what they were taught, he says.

Integrate Across Service Lines

Integration of services also is a key component of good patient handoffs, says **Rohit Uppal**, MD, SFHM, president of Acute Hospital Medicine, TeamHealth, a company in Knoxville, TN, that provides physician staffing and support services.

"We spend a lot of time talking about patient handoffs within a service line, how to hand off a patient from one doctor to the next. Less attention has been paid to how all the departments and service lines are coordinating their efforts for the good of the patient," he says. "As patients come through the emergency room and need to be admitted to the hospital, we work to ensure good communication through that continuum as soon as possible.

That means good communication around clinical issues and coordination of care."

For instance, the company encourages parallel processes rather than waiting for one physician to complete care before the next begins. One challenge is that in many hospitals, communication lines between services is asynchronous, Uppal says.

"People are depending a lot on documentation and reading each other's notes. If you can design workflow so that you have more verbal interactions, you can have people asking questions more freely and cut through a lot of the inefficiencies in the EMR, with information not being transmitted effectively," he says. "As you have people from different service lines interacting more, they start to understand each other's challenges and they find ways to make the transitions smoother and better for the patient."

Workflows tend to be well-ingrained in service lines, so expect some resistance, Uppal says. Technology also can pose roadblocks, as well as the lack of resources needed to make any change.

"You have to spend a lot of time building the 'why' behind it, because it won't be hard for people to come up with reasons to stick with the way it's always been done," he says. "It's easy for providers to be blind to the negative impact of that lack of coordination and communication. Having leaders who can shine light on the errors, inefficiencies, and quality problems that are occurring can drive clinicians to be more open to change in their workflow."

A football analogy can help explain handoffs with some clinicians, says **Dennis Deruelle**, MD, FHM, national medical director for acute services with IPC Healthcare/TeamHealth, a company providing healthcare professional staff and integrated care providers in Tampa, FL. Think of the patient as the football.

"In a football game, the football is all-important and you never want to fumble it, drop it. People are very careful to take care of it, and in healthcare you have one person handing it to another, with one person as the giver and another as the receiver," Deruelle says. "If either one of them isn't paying attention or doesn't do everything necessary to take care of that football, you have a fumble. When that happens, it's bad and that's where errors happen."

It also is important to get patients involved in good handoffs, Deruelle says. They often have no idea how many times they are handed off from one caregiver to another.

"Patients need to be aware of when they are being handed off, such as with shift changes, and they need to understand the importance of a good handoff. If they think the handoff hasn't gone well, they need to pick up that fumble and protect themselves," Deruelle says. "This requires education and encouraging patients to speak up when they hear the doctor tell someone he's going home that day, when the patient knows he's not. The patient has to know when a handoff has occurred, and when it doesn't occur in the right way they have to fill in the gap." ■

Secondary Heart Failure Affects Readmissions

Heart failure that develops or worsens during a hospital stay can affect outcomes, costs, and readmissions, so hospitals are advised to identify patients at risk for secondary heart failure.

Heart failure is the leading cause of hospital admissions and readmissions in patients older than 65 years, and is a leading cause of death among hospitalized patients, notes **Vlad Gheorghiu**, MSN, NP, AGACNP-BC, PCCN-CMC, a graduate student in the Adult-Gerontology Acute Care Nurse Practitioner Program at the School of Nursing at California State University (CSU), Los Angeles. However, patients who are admitted for a different reason may develop secondary heart failure while they're in the hospital, complicating their recovery.

Gheorghiu's recent research explores possible strategies that nurses and clinicians can use to identify secondary heart failure in hospitalized patients and implement early measures to prevent progression to acute decompensated heart failure. He worked with program coordinator Thomas W. Barkley, Jr., PhD, ACNP-BC, director of nurse practitioner programs at CSU, for the research. *(The article is available online for a fee at: http://bit.ly/2vvtmii.)*

Addressing this risk begins at admission but should continue after discharge, he says. Patients can quickly progress to acute decompensated heart failure if early signs and symptoms of heart failure are not identified in a timely manner.

Early discovery and intervention are important, but should be reinforced along the continuum of care, including after discharge, Gheorghiu says. Reimbursement pressures related to readmissions

and outcomes should be another motivation for hospitals to address this risk, he says.

"The restrictions they're putting on payment and reimbursement are based on outcomes, so it is very important for hospitals and healthcare systems to take measures that prevent complications or lead to longer hospital stays," he says. "It's important to come up with a system that engages patients and providers. The hospitals that have addressed this effectively engaged a wide range of people, including dieticians, pharmacists, case managers — all the people who can provide the necessary elements to make sure the patient is safely discharged home."

Heart failure management should include stratifying risk based on factors such as age, heart rate, blood pressure, diabetes, and existing cardiovascular conditions, he says. An effective program also will focus on recognizing early signs and symptoms, identifying differences between heart failure and conditions with similar symptoms, and correlating assessment results with laboratory data.

Gheorghiu also recommends that a patient's plan of care incorporate guideline-directed medical therapy, management of comorbid conditions and precipitating risk factors, health promotion, and self-care education. At the organizational level, hospital-established protocols should identify and assess patients with potential and existing heart failure, and comprehensive education programs for nurses and other clinicians also may improve outcomes for high-risk patients, he says.

At the hospital where he previously worked, Gheorghiu says, clinicians routinely identified patients with active heart failure and those at risk for heart failure, regardless of their cause for admission.

"Based on that list, we would implement a bundle or protocol of things we had to do with that patient each day or that had to be done prior to that patient's discharge," he says. "For example, we would work with the dietician to provide an appropriate diet when the patient went home, and we would work with the pharmacist to provide education on heart failure medication and how take them. We reinforced symptoms to watch out for at home that could indicate heart failure is worsening, and how to keep track of their weight daily, all to catch symptoms early and keep patients from decompensating."

Gheorghiu says his research found few hospitals utilizing such a protocol specifically to identify and manage patients with secondary heart failure. ■

CE QUESTIONS

1. **In the Inpatient Prospective Payment System final rule, CMS announced that it was adding a 30-day episode of care for pneumonia to value-based purchasing in fiscal 2022. When does the performance period for the measure start?**

   a. Aug. 1, 2018
   b. Oct. 1, 2019
   c. July 1, 2020
   d. It ended on July 1, 2017

2. **According to Susan Wallace, MEd, RHIA, CCS, CDIP, CCDS, FAHIMA, vice president of inpatient services for Administrative Consultant Services, CMS won't put anything in value-based purchasing that isn't already a part of the inpatient quality measures.**

   a. True
   b. False

3. **The Medicare Administrative Contractors (MACs) are expected to start the "probe and educate" process late this year, and can continue it for three rounds. How many charts can the MACs request for each round?**

   a. 20-40, depending on hospital size.
   b. 15-20, depending on hospital size.
   c. 10-25, depending on hospital size.
   d. CMS hasn't announced it yet.

4. **There still is a backlog of hospital appeals of denials by the Recovery Auditors, even though CMS offered to settle with hospitals. What percentage of the disputed amount did CMS offer the hospitals?**

   a. 100%
   b. 66%
   c. 74%
   d. 50%

HOSPITAL
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